RETINA NORTHWEST, PC

PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I understand that Retina Northwest (RNW) will use and disclose health information about me.

I have received a copy of RNW's Notice of Privacy Practices, effective September 23, 2013. This notice describes how RNW and its physicians, employees, staff and other office personnel may use and disclose health information about me. It explains my rights with respect to my health information and how I can exercise these rights.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon my request.

By signing below, I agree that I have reviewed and understood the information and that I have received a copy of the Notice of Privacy Practices.

Signature: ______________________________ Date: ____________ DOB: ____________

Description of Patient Representative's Authority (if not signed by patient)____

Release of Information Authorization

Many patients have a spouse, relative(s) and/or friend(s) who helps with and is involved in their medical care. In order for us to share information about your care with these people, we need a release from you. Please list below those people with whom we can discuss your medical care, including your appointments, medical conditions, recommended treatments, and account payment arrangements.

Name	Birthday	Relationship	Phone Number

______________________________ ____________ ____________
Patient Signature Date DOB

Revised 9/23/2013